Answers to Written Questions
AHCCCS RFP # YH06-0011, Medical Reviews

RFP Section	Para. #	Page #	Question	Response
Offer & Acceptance	N/A	3	Must a proposer have an Az Sales Privilege Tax License Number prior to submitting a proposal?	No, but a proposer must submit a Federal Employer Identification (FEI) number with the proposal.
Scope of Work	2.2 & 2.4.1	4-5	The RFP states that AHCCCS is seeking a Quality Improvement Organization. Since "QIO-like" designation from CMS qualifies states for 75% federal match, will proposals from QIO-like organizations be accepted as equally qualified as a QIO?	Yes, if the qualifications are met. AHCCCS collects the 75% federal match in that instance.
	2.3	4	Will the Division of Fee for Service (DFSM) Prior Authorization Unit continue to perform the functions it historically has performed, or does the change in language from "prospective reviews" to "admission, preadmission, and preprocedure reviews" constitute a change in the agency's approach to Utilization Management and the tasks assigned to the contractor?	The agency may elect at any time to utilize this contract for any of the functions outlined in the RFP. The purpose of the RFP is to allow AHCCCS that capability. The terms used in the RFP are those currently used in the CFRs.
	2.9	5	Is there a specific nationally recognized, standardized review criteria required?	The AHCCCS FFS division (Division of Fee for Service Management) has adopted Inter Qual criteria.
	3.3	6	What does AHCCCS expect regarding its statement that the Contractor will monitor patient care including for "risk control and infection surveillance systems"? What type of issues is AHCCCS expecting the Contractor to identify; how are these terms defined within the scope of the contract (they are not included in the list of definitions)?	In the normal course of retrospective or continued stay review, any potential risk incident, or nosocomial infections should be reported to AHCCCS for Quality reporting and review.
	3.4	6	What is inter-rater reliability?	A mechanism to validate that staff involved in applying medical necessity criteria do so in a consistent and standardized manner.
	3.4	6	Is there a certain percentage of cases to be re-reviewed for inter-rater reliability?	The Contractor's own policy would define the percentage of cases reviewed or mechanism to validate staff. AHCCCS would monitor via Contractor oversight.
	3.6	6	The RFP states that the contractor's admission and continued stay review responsibilities commence within	DFSM normal business hours are Monday – Friday 8 A.M. to 5 P.M., excluding state holidays. The standard would apply to those normal business hours.

			24 hours of notification by AHCCCS. Is the contractor required to have 7 days a week/24 hrs a day operations for prior auth & continued stay review activities?	
	3.6	6	Does "commence within 24 hours" also mean one working day?	Yes
	3.7	6	What has been the annual volume of continued stay/retrospective reviews performed for other populations, such as inmates and behavioral health patients?	There is currently no mechanism to separate inmates and behavioral health patients. These members may be at any AHCCCS facility.
	3.8	6-7	What are the annual volumes for procedure reviews, preadmission prior authorizations, prior authorization reconsiderations, continued stay reviews, and retrospective reviews? What are volumes by location for all review types?	The best statistical data available is reported on page 55 of the RFP. AHCCCS has not had the capabilities to report in any other format.
	3.8	6-7	What are the anticipated review volumes for the following two categories of services: medical/surgical and behavioral health?	It is impossible to forecast anticipated review volumes.
	3.8.1	6-7	Will AHCCCS continue to provide prior authorization for any services? If yes, what services will AHCCCS prior authorize, and what services will the review organization be asked to prior authorize?	AHCCCS will utilize this contract as a supplement to existing services. All AHCCCS FFS guidelines for what services require authorization will be adhered to.
	3.8.2	6	How will the contractor be notified of admissions to an inpatient facility (telephonic/fax, etc.)?	Currently, the contractor is notified via fax of the prior authorization screen or facility notification.
	3.8.2	7	Continued Stay Review-- Please confirm that AHCCCS will notify the Contractor when to initiate a continued stay review for both inpatient and for long term care. If AHCCCS will not provide notification, how is the Contractor to be informed of the need for continued stay review?	Notification will continue from AHCCCS. All facility providers will continue the existing notification process.
	3.8.2.1	7	Are acute, nursing facility, and long term care considered as separate reviews & are they priced separately?	Reviews are classified based on type of review, not on location or member classification.
	3.8.2.2	7	If notification of admission is received prior to receipt of all necessary medical documents, when does the "24 hours of	24 hours begins with notification. If documentation regarding medical information is missing, it is the Contractor's responsibility to obtain that

			notification of admission" clock start?	information in the course of the review.
Statute	3.8.3	7	What is the contractor's responsibility in paying for medical records in order to conduct a retrospective review?	Statute prevents a provider from charging for a record of a Medicaid member.
	3.8.3	7	May the vendor identify cases for retrospective review?	No, AHCCCS will determine what cases require retrospective review.
	3.8.3.2	7	Medical and Claims Reviews—Please provide a further description regarding the anticipated volumes and types of cases that are anticipated to be sent for claims review (e.g., types of services to be reviewed, types of billing issues to be reviewed, and types of coverage issues to be reviewed).	AHCCCS cannot project volume. The types of reviews will depend on AHCCCS identified trends or variances, and can range from dental claims and coverage criteria application, to review of level of care provided.
	3.8.3.2	7	Please clarify "claims reviews with regard to medical necessity, appropriateness of charges, and utilization of covered benefits." Does appropriateness of charges imply a line item review? Also, would these retrospective reviews' pricing be placed on page 13/7.4.1.3 or page 14/7.4.2.1 or both?	The proposer should submit rates based on the particular function. Retrospective review may be line item. The proposer may submit rates for either or both per case or hourly.
	3.8.5	7	The RFP states the Physician Advisor shall interact with the attending physician directly, when requested by AHCCCS, the patient's family, or attending physician. Could a Peer Reviewer or the contractor's Medical Director do this activity?	Any qualified health care professional may communicate with the patient's family or attending physician upon AHCCCS request. Solicitation Amendment #2 amends this requirement to add "any qualified health care professional."
	3.8.4.5	7	Does "Discharge needs" mean review of these needs or arrangements and follow-up of these needs?	AHCCCS expects the "discharge needs" assessment to be inclusive of both the planning for post-facility needs, participation in that planning, and assuring the plan is executed appropriately.
	3.8.6	7	This sections states that all retrospective reviews for medical necessity must be performed by the Physician Advisor. Does this mean that all denials and/or adverse decisions must be made by a Physician Advisor, i.e., a qualified nurse reviewer may approve a medical necessity issue based on approved criteria, but will refer an non-approved case to a Physician Advisor? May the Medical Director perform these reviews & must the clinical	The Medical Director must be a qualified health care professional, and by definition and training in the Medical Director role, is qualified to make/apply criteria and make determination decisions. All initial criteria application can be done by a qualified professional which may include a nurse, therapist, etc. Only a Medical Director can determine if a denial is warranted.

			specialty of the Medical Director/Physician Advisor be in the same or similar clinical specialty as the services or physician being reviewed?	
	3.8.4.2; 3.8.7	7	Please define "Quality of Care." Please provide or describe the guidelines, screens, or other tools AHCCS uses.	Quality of Care issues are those that pose risk, do not comply with accepted standards of care, or constitute a complaint that must be investigated. The AHCCCS FFS Manual has a format for reporting what the Contractor will utilize.
	3.8.8	8	The RFP states that denial, termination, or reduction of services must be clearly documented as to the review process, & rationale for the action and directed by the Physician Advisor. Could a Peer Reviewer or the Contractor's Medical Director do the initial review and a Physician Advisor do a 2nd level review if the determination is appealed?	See 3.8.6 answer, above.
	3.8.9	8	Does the reference to the "AHCCCS Notice of Action Policies" refer to Arizona Administrative Code Title 9, Chapter 34, Grievance System Articles related to the "Notice of Action?" If not, please clarify what is meant.	Yes, AHCCCS is bound by both the Arizona Administrative Code and 42 CFR 438.404. Additionally if the Contractor is reviewing a Health Plan contracted to AHCCCS, any specific contract language is applied.
	3.8.10	8	What is a "focused review" and approximately how many focused reviews will be performed in a year?	A focused review would be an in-depth review based on initial adverse findings. AHCCCS is unable to determine the volume of these reviews.
	3.8.11	8	What is the anticipated number of hours per year required for consulting services?	AHCCCS is unable to project the anticipated number of hours required for consulting services. The budget is currently not approved, and therefore, the amount of dollars available is not public. The agency used approximately 4,000 hours in 2004 for reinsurance/retrospective reviews.
	3.8.11	8	If medical services are considered experimental in nature, what is the scope of this and what financial responsibility might the contractor have?	AHCCCS does not cover experimental services. See A.A.C. R9-22-201-B.10.a. (available at www.azsos.gov/public_services/Title_09/9-22.htm).
	3.8.12	8	How many reinsurance reviews are expected to be performed in one year? In one month?	AHCCCS is unable to accurately determine the volume as the process is changing to conduct these reviews, based on data received through the AHCCCS Data Warehouse, which has just become operational. The range could be from 10-

				45 per month.
	3.8.12	8	How should pricing for reinsurance reviews be reflected on the pricing schedule? 7.4.1.1/page 13, or 7.4.2.1/page 14, or both? Are they priced as hourly or per review?	Both or either. AHCCCS will determine how it will pay the request at the time the Contractor is notified. It is expected that for standard reinsurance reviews that the per case price will apply. Productivity studies project a case to take an average of 30 minutes. For line item or claim review, it is projected that an hourly rate will apply. AHCCCS reserves the right to contract the function at either price.
	3.8.13	9	How many grievance support cases can be expected for one year? In one month?	AHCCCS cannot determine this as this is a new function. AHCCCS historically has a variance in hearing ranging from none to 10 in a month. The Contractor would only be involved in the initial or appeal decision.
	3.8.13	9	Approximately how many physician hours are expected to be requested in one year, and how many reviews are expected to be performed in one year?	AHCCCS cannot project this volume, and the physician hours would vary by type of function, i.e., physician involvement is at a higher level in continued stay reviews than in retrospective reviews.
	3.8.13.2.1	9	What is the anticipated number of cases that will require an expert reviewer's attendance at a grievance hearing and/or court proceeding?	AHCCCS feels this will be rare and only for cases where the reviewer was involved in the decision.
	3.8.13.2.1	9	What is the anticipated number of reviews for case denial at the grievance level per year?	Please see response for 3.8.13.2.1.
	4.2	10	The RFP states, "Data must be submitted on diskette in an ASCI format, with comma delimited." Please clarify.	This is a format choice when saving the file.
Pricing Schedule	2	11	Should travel and expenses (hotels, meals, etc.) inside Maricopa County be considered in the contracted rate for Reinsurance Reviews? (Historically, these reviews take longer and may involve several days at a specific healthplan.)	AHCCCS has rewritten the Health Plan contract and eliminated the health plan on-sight review. Any records requested will have the records sent to AHCCCS or the contractor. Travel for non-urban areas is reimbursed separately and guidelines are addressed in the RFP on page 11. Travel within the urban areas should be built into the administrative cost portion of your proposed rates.
	2.1	11	Should our fee include travel reimbursement? If not, what are the guidelines?	See the above response.
	3.2	11	Please define gatekeeper.	Gatekeeper is managed care terminology and is defined by Medline as: "a health-care professional (as a primary care physician) who regulates access especially to hospitals and specialists."

				Managed care plans rely on a designated physician *gatekeeper* to orchestrate and control the health care of its enrollees.
	4	12	Under "Unaccepted Work," what is the standard for work performed? Does AHCCCS have a particular form or template to complete to ensure satisfactory standards? What constitutes rejected work?	Work must meet the intent of the Scope of service. AHCCCS will provide any training regarding expectations for specific scope of work. Rejected work is that which does not meet the criteria on which the contractor was trained.
	7.4	13	The RFP requires that Arizona-licensed physicians and nurses will be utilized. Would an Az registered nurse and an Az physician who are assigned supervisory authority over the services performed by nurses or physicians licensed in other states be sufficient, or is this RFP intended to be limited to the Arizona QIO only?	The RFP is not limited to Arizona QIO's; however, AHCCCS requires the following: A Medical Director who is an Arizona-licensed physician; Medical Management Coordinators must be Arizona-licensed Registered Nurses, Physicians, or Physician's Assistants; Prior Auth staff who authorize health care must function under the direction of an Arizona-licensed Registered Nurse, Physician, or Physician's Assistant. Concurrent Review staff must be Arizona-licensed Registered Nurses, Physicians, or Physician's Assistants.
	7.4	13	This item states, "Whether the Total Composite Rate per Case or Hourly rates will apply for service will be determined by AHCCCS when the services are requested." Under what circumstances will this decision be made? What is the estimated volume of cases in which an hourly rate will be used? What is the estimated volume of cases in which a per case rate will be used?	Per case rates will generally be used for retrospective or reinsurance cases where productivity standards are known. Hourly rates will be utilized for DFSM Support Services. Please also see response in 3.8.12.
		13	Can AHCCCS amend the Pricing Schedule to make a separate category for reinsurance review? We do not believe they are comparable to other types of retrospective reviews. They are more extensive.	See Solicitation Amendment #2.
	7.4, 2nd para	13	Will the method of payment be made on a case by case basis (e.g., one retrospective case is paid on an hourly rate basis, but the next one is paid on a rate per case), or for a specific service (e.g., continued stay review is paid on an hourly rate basis, but retrospective review is paid on a rate per case basis)?	AHCCCS will indicate the type of payment when the services are requested. See responses to 3.8.12 and 7.4.
	7.4.1	13	Shall the contractor establish a case rate & an hourly rate based on onsite review as well as telephonic review? If so, will the	Solicitation Amendment #2 has been done to include rate differences for on-site and telephonic reviews.

			Pricing Schedule be amended to allow for this?	
	7.4.1.1	13	What are the types of pre-procedure & pre-admission reviews & what has been the associated volume on an annual basis?	Pre-procedure reviews include procedures which require prior authorization, and pre-admission reviews are for planned hospitalizations.
	7.4.1.2	13	What has been the volume of referrals for continued stay reviews by county and by facility on an annual basis?	AHCCCS is unable to provide this information--see Pg. 55 of 61 in the RFP, as well as the response to 3.7.
	7.4.1.3	13	What has been the annual volume of retrospective medical claims review referrals? What has been the annual volume of reinsurance reviews?	There is no mechanism for differentiating, as the only records available are invoices which do not differentiate the type of work performed. The agency used approximately 4,000 hours in 2004 for reinsurance/retrospective reviews. See response to 3.8, also.
	7.4.1.4	13	What has been the annual volume of focused review case referrals?	This is unknown- see responses to 3.8 and 7.4.1.3.
	7.4.2.2	14	There are only two categories for consulting services hourly rates—Physician & R.N. In describing the task on page 8 (3.1.11.2.3) of the RFP, "data search services" is a component of this task. May the proposers include an hourly rate for a health data analyst position?	No, your rate should include administrative costs.
	7.4.2.4	14	What has been the annual volume of in-person appearances (e.g., hearings)?	We have not utilized this service in the past. See the responses to 3.8.13.2.1.
	7.4.2.5	14	Appearances--there is a request for pricing for this on the Pricing Schedule; however, there is no related specification in the Scope of Work. Please provide a description in the Scope.	When a case is appealed through an Administrative Law Judge, the party involved in the decision must defend the rationale and criteria for the basis as described in 3.8.13.2.1
	N/A	N/A	During the Bidders' Conference there was discussion regarding how unit prices are to be listed. Please confirm and clarify the following issues regarding the pricing for this RFP: a. How reinsurance reviews are to be priced and which review type b. How the offeror can reflect telephonic and on-site reviews c. What is the intent of how the case rate and the hourly rate are to be used—in other words, in what circumstances the case rate will be used and in what circumstances the hourly rate	See Solicitation Amendment # 2 for assistance with this. The offeror will reflect type of review on their billing which is subject to AHCCCS audit. AHCCCS determines the type of service being requested-see pg 13 of RFP 7.4.and the responses to 3.8.12, above. Claim reviews are retrospective and should be priced accordingly.

			will be used d. How the claims reviews are to be priced and which review type	
Uniform Instructions to Offerors	1.50	18	CMS does not contract with any organization to provide Medicaid services. Under the Social Security Act, CMS contracts with a QIO with respect to Medicare beneficiaries. Is this a typo, or is this RFP intended to apply only to an organization which already contracts with AHCCCS (i.e., the Arizona Medicare QIO)?	Delete the definition of QIO, and instead refer to "Scope of Work," amended 2.2 and 2.4.1.
	3.10	21	What State taxes are applicable?	State taxes and law are based on the organization's status.
Special Instructions to Offerors	4.1	27	Can LPNs be utilized for medical necessity review if supervised by RNs?	Yes, they can apply standardized criteria under the direct supervision of an RN.
Uniform Terms & Conditions	46	37	Termination for Convenience—Is there an option for the contractor to terminate the contract with AHCCCS? Is there an option for the contractor to terminate the contract for non-availability of funds?	There is no termination for convenience provision for the contractor. Regarding non-availability of funds, please refer to Uniform Terms & Conditions, p. 30, "Availability of Funds for the Next Fiscal Year." This is the only clause that addresses availability of funds.
Special Terms & Conditions	28.2	48	Ownership of Information & Data-- What is the contractor's requirement/timeframe for storing medical records after the completion of the review?	Records must be available for a six (6) year period from the time of any decision.
Exhibit A – Hospitals in AZ	N/A	49	What is the number of on-site initial reviews anticipated per hospital by review type: prior auth & continued stay?	See pg 55 of 61. Continued stay review data does not include prior authorization data.
	N/A	49	In the event of a temporary staffing shortage due to illness or other unplanned situation, is it ever acceptable to conduct telephonic reviews at facilities where on-site initial reviews are expected?	Yes, subject to AHCCCS approval.
	N/A	49	Please clarify if all "initial reviews . . . unless otherwise noted" must be done onsite or is telephonic acceptable?	If the facility has an indication that telephonic is the primary method for review from that facility, then an on-site review is not required.
	N/A	49	a. Please clarify for what types of reviews on-site reviews are required—when pre-admission review was not performed (due to emergent or weekend admissions)? for the initial continued stay review? for what other situations?	If the facility has an indication that telephonic is the primary method for review from that facility, then an on-site review is not required. Continued stay reviews can be performed telephonically if there is an asterisk by the facility.

			b. Can you supply projected on-site review volumes by county and facility? c. Please confirm that as stated at the Bidders' Conference, AHCCCS requires the Contractor to conduct on-site reviews if a facility refuses to conduct telephonic reviews.	No, please see the response for 3.7 and 3.8. Yes, if a review is required and the facility will not provide telephonic information. The barriers to obtaining information do not negate the fact that the review is still required.
Exhibit D – Offeror's Financial Disclosure	N/A	52	Is a set of financial statements to be returned with the proposal?	Financial statements have not been requested; however, they may be submitted as "additional information" (see p. 28, #4.4).
Additional Information	N/A	55	Based on the 10-month table, what are the anticipated numbers of prior authorization reviews and continued stay reviews for the next contract year?	It is impossible to forecast anticipated review volumes.
	N/A	55	What are the criteria for a case to be referred to HSAG?	There are no criteria for referral to HSAG. If the question is when will this contract be accessed, then it will be based on the needs for the Division of Fee for Service Management (DFSM), or the Division of HealthCare Management (DHCM).
General Questions	N/A	N/A	What is the award amount for this contract for the current contract year? Is there a cap on available funds?	Health Services Advisory Group (HSAG), the current provider, has more than one contract with AHCCCS. The Finance Dept. does not track payables by contract number, but by vendor. Total annual payments to HSAG for all contracts for each of the last few years has ranged from $677,000 to $864,000. There is no "cap" but each division submits an anticipated budget amount for approval. If additional funds are required during the year, then these are subject to approval.
	N/A	N/A	Is it correct that the cost portion of the proposal should be included as a separate tab in the proposal and not a separate cost proposal?	Yes, separate tab in the proposal.
	N/A	N/A	Who is the current contractor and how long have they held the contract?	Health Services Advisory Group is the current contractor, and the current contract began in 1999.
	N/A	N/A	What is the approximate length of transition between contract award and contract start date of 4/1/06? When will proposers be notified of award?	Transition time will be dependent upon awardee, training needs, and type of activities requiring transition.
	N/A	N/A	Are hospital inpatient stays reimbursed by DRGs? If not, how are they reimbursed?	Only Medicare pays by DRG. The reimbursement for the population to be reviewed is fee for service or is based on contracts between health plans and hospitals.
	N/A	N/A	To what extent are the services of a medical coding specialist	Not required, since this is a medical review contract.

			recommended or required to fulfill the service requirements of the solicitation?	
	N/A	N/A	What criteria or policy guidance does AHCCCS utilize regarding medical necessity of admission or services? What state-specific criteria have been developed by AHCCCS? What process is followed if the Contractor determines that state criteria might need updating (e.g., something is determined to not be medically necessary by the criteria, but is considered standard of care by the physician reviewer)?	InterQual and medical necessity are the basis for initial and continued stay review. Standard of Care decisions are made through the AHCCCS New Technologies Committee.
	N/A	N/A	What services require prior authorization – all elective hospital stays? All outpatient surgeries or selected procedures? Any medical or diagnostic procedures (e.g., MRI, CT, therapies)? Other?	Please refer to the AHCCCS Medical Policy Manual and Fee For Service Manual. The prior authorization criteria for the FFS population is set by the DFSM.
	N/A	N/A	What criteria or policy guidelines does AHCCCS utilize regarding emergency medical services for undocumented persons? Are any after-care services related to an emergency or services to prevent an emergency (e.g., oxygen) covered?	The Federal definition of emergent care, and post stabilization are covered per the BBA definitions.
	N/A	N/A	Please clarify the expectations regarding physician review – is/are the Physician Advisor(s) expected to review all prior authorization cases? What is the monthly caseload and case-mix of these that can be anticipated?	The Physician should be involved in cases that do not meet standard criteria. The number of cases presented to the Medical Director are not currently tracked, and therefore, AHCCCS is unable to provide this information.
	N/A/	N/A	Please further clarify the definition of "peer review." Is the same professional field considered to mean same type of licensure (e.g., MD, RN, DPM) or do reviewers need to be matched by same-specialty type (e.g., surgeon for surgery cases), as well?	Peer review is generally based on specialty, so that a qualified reviewer is utilized.
	N/A	N/A	What type of involvement in reconsiderations is expected of the Physician Advisor(s)?	If an initial request is denied, and requesting provider would like a second review.
	N/A	N/A	What is AHCCCS' expectation regarding claims review – are there specific cases designated for this type of review by AHCCCS? Does each case involve review of a patient's previously covered	AHCCCCS will select claim reviews based on variances to billing, high dollar cases or high risk. Previous claims will only be part of the LTC member's review as they are included in the reinsurance criteria. The review centers around medical necessity,

			claims for services? Please describe in more detail what might be involved in this aspect of the Scope of Work.	level of care provided and billing reflective of care provided. Delays in discharging, number of days and clinical care provided are the most frequent issues identified through this process.
	N/A	N/A	For pre-authorization review, what is the expected turnaround time that the Contractor needs to meet to handle requests? Does it vary by request type?	See Federal Standards definitions of urgent and standard under 42 CFR 438.210.a.
	N/A	N/A	Aside from the contractor's Medical Director, is there a need for other medical specialties? If so, how many are needed and what specialties would you prefer?	Generally no other medical specialty is required, though this could occur and the contractor would be expected to contact a particular specialty.
	N/A	N/A	What organizations have submitted questions in response to this RFP?	This will become public information after contract award.
	N/A	N/A	AMPM - Chapter 800: a. Please clarify whether providers will continue to directly contact AHCCCS for authorization of all review services? b. If providers initially contact AHCCCS, how will the review contractor be notified for each review type? c. Please clarify what anticipated volumes are for the Contractor by the healthcare services types listed as requiring prior authorization	Yes, AHCCCS will continue to serve as the direct contact to the providers. Fax or telephonically. See response to 3.8.2. AHCCCS cannot anticipate volumes, and does not currently track by health types, i.e, DME, specialists.
	N/A	N/A	In Chapter 800 of the AHCCCS Medical Policy Manual (AMPM) , which is referenced in the RFP, there is discussion of fee-for-service utilization management review procedures. The following questions (a. – c.) are submitted in regard to Chapter 800: c. Please clarify whether providers will continue to directly contact AHCCCS for authorization of all review services? d. If providers initially contact AHCCCS, how will the review contractor be notified for each review type?	Yes, AHCCCS will continue to serve as the direct contact to the providers. Fax or telephonically. See response to 3.8.2

			c. Please clarify what anticipated volumes are for the Contractor by the healthcare services types listed as requiring prior authorization	AHCCCS cannot anticipate volumes and does not currently track by health types, i.e. DME, specialists.
	N/A	N/A	RE: Prior Authorization and Retrospective Reviews: a. Will the Contractor have access to eligibility information? If so, how will this access be provided? If not, will AHCCCS confirm the member's eligibility prior to referring the review to the Contractor? b. Will AHCCCS verify the provider status as an AHCCCS-registered FFS provider prior to referring the review to the Contractor? If not, how will the Contractor get access to this information? c. Will AHCCCS confirm that the service requested is an AHCCCS covered services prior to referring the review to the Contractor? If not, how will the Contractor get access to coverage information? d. Will AHCCCS verify that the service requested is not covered by another payer (e.g.., commercial insurance, Medicare, other agency) prior to referring the review to	Upon notification of the need for review, the eligibility information will be provided via fax or through the eligibility screen provided. Yes, through the AHCCCS prior authorization request process. Any provider with an AHCCCS identification number can accept an AHCCCS member. No, it is the responsibility of the contractor providing prior authorization services. The purpose of the contract is for support on the prior authorization determination process. The contractor will be instructed how to access the AHCCCS coverage criteria during the implementation phase. Coverage information is available in Chapters 300 and 800 of the AMPM. This will be provided through the eligibility screen and should be coordinated by the Contractor reviewing the request.

			the Contractor?	
	N/A	N/A	In the AHCCCS Reinsurance Claims Processing Manual, there is discussion regarding the AHCCCS tier levels. Please clarify or describe the AHCCCS tier levels and how the Contractor must take that into consideration in the review process. Also, please clarify the criteria that are used for reviewing the reinsurance claims, including the document/manual in which they are located.	The AHCCCS Claims Processing Manual is under revision and will be completed and approved prior to the initiation of the contract. Tier levels are described in the manual and include applying criteria on levels of NICU care and Critical Care standards as well as surgical or medical admissions. The successful Contractor will be provided both the manual and training at the implementation of the contract.
	N/A	N/A	Does AHCCCS pay differentially based on various acute inpatient levels of care? If so, will the contractor have access to the fee schedule to be able to report on savings?	Tier levels are used for subcontractors (providers). The fee schedules are available on the AHCCCS website at www.azahccc.gov. Then click on "Plans & Providers," "Rates and Codes," "Fee-for-Service Rates."
	N/A	N/A	During the Bidders' Conference, there was discussion regarding Chapters 800 and 1000 of the AMPM. Although Chapter 800 is particularly focused on fee-for-service UM, Chapter 1000 appears to be applicable to managed care although parts of Chapter 1000 also appear to apply to this scope of work (and are referenced in the RFP). Please clarify which sections of Chapter 1000 apply to this contract. Also, please clarify which Chapter takes precedence. In some cases, there appears to be some conflicting information between these two chapters. For example, Chapter 1000 indicates that preauthorization must be offered 24 hours/7 days per week while Chapter 800 does not indicate that requirement. It would be helpful to have clarification on how and when these two Chapters of the AMPM apply to this contract.	Chapter 800 applies to FFS. Chapter 1000 applies when reviewing Health Plans. The precedence is dependant upon the eligibility type of the member. Many medical management expectations that apply in the Managed Care Health Plan arena are not applicable to the FFS member, and thus, not addressed or have a different standard as seen in Chapter 800.
	N/A	N/A	Can proposers bid only on certain sections of the RFP?	Yes